

Senate Health, Human Services and Senior Citizens Committee
Remarks by Commissioner Jennifer Velez
June 23, 2011

Good morning, Chairwoman Weinberg, Vice-Chairman Vitale and members of the Senate Health, Human Services and Senior Citizens Committee. I'm here at your request, to discuss the state's Medicaid reform efforts and specific aspects of the initiative that were raised during a provider roundtable, held by this Committee a couple of weeks ago.

Joining me today are members of the Department's Medicaid team including, Director Valerie Harr, Chief of Operations Carol Grant, Director of the Office of Managed Health Care, Karen Brodsky and Supervisor of Customer Services, Eileen Calabro.

There are a number changes contained in this Medicaid rebalancing and reform effort, as it pertains to the FY'12 budget initiatives and the Comprehensive Medicaid Waiver. I hope today's hearing will clarify and distinguish the details of each. Although they are together part of a reform package, each will advance through a different process.

In the upcoming state Fiscal Year 2012 budget, Medicaid will cost New Jersey taxpayers nearly \$5 billion. The loss of about \$1 billion in stimulus funds, coupled with the 22% growth in the program since Fiscal Year 2007, created a need for NJ – and many other states throughout the country – to truly evaluate the program. This past February, the Governor discussed in his budget address a need to restore balance and efficiency to Medicaid.

I think it's fair to say – and many of you on this Committee may agree – that Medicaid is ripe for reform. We may debate the how and when but the state must redesign the program if we expect to protect benefits to the most vulnerable – the very low-income, the aged, blind and disabled populations and children.

In our current program, there are many things that are done well and are indeed a source of pride, but other areas are fragmented and in need of restructuring. In response to the Governor's instruction, our Medicaid management team and the leadership of other departments dug in – reviewing every facet of the program, examining other states' plans, looking at every possible opportunity to improve and to reform.

The result is a two-part strategy that includes initiatives incorporated in the FY'12 budget proposal and the Comprehensive Medicaid Waiver concept paper, which will be submitted after the state budget has been finalized and stakeholder input has been received and considered. Overall, I believe this is a reasonable and comprehensive reform package that reflects and incorporates best practice models and advances innovation.

Beginning July 1 through the early fall, nearly all categories of Medicaid fee-for-service clients will be carved into managed care. The aged, blind, disabled and chronic illness populations are included, as well as prescriptions. It is a process that has been shown to effectively and positively

impact patients' health-related decisions, eliminate duplicative services and improve health outcomes at a considerably reduced cost.

At this committee's roundtable hearing, some individuals testified that the Department was moving too quickly with the carve-in, that a sound network of providers was not yet in place and that continuity of care would be jeopardized. But it should be noted that Medicaid managed care is not new to New Jersey. It was launched in 1995 for the TANF and NJ FamilyCare populations. Over the years, it was expanded to other Medicaid populations.

Currently, more than 75% of Medicaid's 1.2 million clients are enrolled in managed care including, nearly 120,000 individuals who are aged, blind or disabled. In July and August, we will have mandatory enrollment for 45,000 – a fraction of our Medicaid client total. In short, ours is a program well prepared to serve special needs consumers. The philosophy of care management is broadly relevant, especially for the most medically fragile Medicaid members.

This carve-in shift also has encouraged many providers who may have previously resisted contracting with HMOs to partner in the system. And the HMOs are actively expanding their provider networks with signed contracts to ensure accessibility and specialty care options.

In a related issue, during the roundtable, a woman provided remarks about her husband's emphysema and his need to see a physician in New York because there were no physicians locally that could treat his chronic and long-term medical needs. While we know of at least two of our HMOs that do have specialists in her area – let's assume for a moment that we didn't. The mandatory carve-in provides for continuity of care. This is a very important point.

All services currently provided through the Fee-for-Service model under Medicaid will be continued with the managed care plans until full assessments can be completed and equal care can be arranged within network. This includes grandfathering in antipsychotic and anticonvulsant prescriptions, covering treatments for hemophiliacs and securing short-term contracts with providers as their credentialing process for HMO participation is pending. But, if equal care still cannot be arranged for a client in-network, the care will continue through an out-of-network fee-for-service contract.

This doesn't mean that there won't be challenges or snags along the way. But this Department and the Medicaid division are committed to meeting the needs of clients throughout the process.

In May, the Department submitted to the federal government a concept paper detailing the reform measures we want to pursue. This requires CMS approval.

The concept paper includes ideas for effective, short and long-term, cost-controlling improvements to Medicaid. As you know, a waiver is necessary to make changes to categories of Medicaid, for which the federal government provides partial funding. The goal of this proposal is to give New Jersey the flexibility it needs to define who is eligible, the benefits they receive and the most cost-effective service delivery.

One component that has been highlighted most by the Legislature, as well as the media, is the requested parent freeze in an expansion category above TANF level – about 30% of the federal poverty level. This is clearly a controversial initiative that has, unfortunately, detracted from the other proposals and big-picture view of the reform package.

I think it's essential to say first that the waiver does not impact the eligibility of individuals who are currently covered. It does, however, impose stricter income standards for new applicants. I know this is a delicate issue and I have testified before that the State has frozen parents in previous, difficult budget years – arguably none as tough as the one we're considering. Not everyone is convinced of the merits of that rationale, but I want to restate our commitment to ensuring continued healthcare coverage for children.

Most importantly, the waiver serves as a vehicle to evolve the program to promote home and community-based care instead of institutionalization or nursing homes; integrate primary, acute, long-term and behavioral health care; encourage healthy behaviors and member responsibility for their health care decisions; re-bid the state's managed care contract; and, support families' ability to afford private third-party insurance with Health Insurance Premium Payment assistance.

The Department values and understands there is no Medicaid program without medical providers and that for many – modern managed care requires significant adjustments. We are working particularly closely with the fee-for-service providers to help them with the changes and to learn about Medicaid managed care.

There are components in the waiver that revise payment rates to providers, incentivize contractual relationships between HMOs and hospital systems, support integrated care around hospitalization, and pilot a demonstration project that would allow New Jersey to revise its current payment structure for hospitals.

The waiver also will encourage innovative, integrated health care delivery systems by creating opportunities for providers to serve individuals who are aged or living with disabilities in the community rather than in nursing homes or institutions. This will facilitate the state's implementation of *Olmstead* - a court mandate and a civil rights issue that New Jersey is committed to fulfill.

These are our goals: worthy and – some would say – long overdue. Our work has been wide-ranging, but thoughtful and planful. The recommendations we made in the FY'12 budget are before the Legislature and are guided by its actions and the Governor's approval. In the meantime, the Department will continue to meet with groups impacted by these changes, and refine these ideas further before we submit our formal waiver application to the federal government.

I'm happy to answer questions you may have. Thank you.